

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027533

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 362

FILED AUG 12 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY	Cape Girardeau	a. STATE	Missouri
b. CITY (If outside corporate limits, give TOWNSHIP only)	Cape Girardeau	b. COUNTY	Cape Girardeau
OR TOWN		c. CITY OR TOWN	Jackson
c. FULL NAME OF (If NOT in hospital, give location)	St. Francis Hospital	d. STREET ADDRESS	909 Morton
HOSPITAL OR INSTITUTION		(If outside, give location)	
Length of stay in 1b	3 1/2 hrs.	Inside Limits	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED		4. DATE OF DEATH	
(Type or print)		Month Day Year	
John Wilson LaPierre		July 25, 1963	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
Male	White		12/16/1907
9. AGE (last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
55	Invalid	Jackson, Mo.	U.S. A.
13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE	
W. C. LaPierre	Don Norman	-----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
No	N/A	Mrs. Chas. LaPierre, Jackson, Mo.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)			
Pneumonia			
DUE TO (b)			
Infectious			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.	
Associated lipid pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
+ Dehydration. Cerebral atrophy			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY	Hour a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from July 25, 1963 to July 25, 1963 and last saw her alive on July 25, 1963			
Death occurred at 3 P.M.		m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
J. E. Hecker, M.D.		Jackson, Mo.	July 30, 1963
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county)
Burial	7/27/1963	Russell Heights	Jackson, Missouri
24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
J. N. Boudinot	Jackson, Mo.	8-9-1963	Chas. Raster

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0168

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

E. C. Craight

Licensed Embalmer No.

4327

P. O. Address

Jackson, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.